

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034095

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8888

DO NOT WRITE
ON THIS STUB

AMENDED

FILED SEP 6 1963

| | | | |
|--|---------------------------|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis | | Length of stay in 1b 35 yrs | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word Hosp | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. STREET ADDRESS 5050 Ruskin | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARY SCOTT | | 4. DATE OF DEATH Month Day Year Sept 1 1963 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7/13/1876 |
| 9. AGE (last birthday) 87 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (City and state or country) New Orleans La | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME John Mahony | | 13b. MOTHER'S MAIDEN NAME Mary Elms | |
| 14. NAME OF HUSBAND OR WIFE dec'd | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Virgil Scott 5050 Ruskin Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure Symptomatic Pulmonary, Bronchitis Chronic Arteriosclerosis Chronic Arthritis Chronic Cerebrovascular disease DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 10 1/2 months 4 years | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 4200 H | | 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION St Louis Mo | | COUNTY STATE | |
| 21. I attended the deceased from 2/14/63 to 9/1/63 and last saw her alive on 9/1/63 Death occurred at 11:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) George J Milan M.D. | |
| 22b. ADDRESS 3903 Olive | | 22c. DATE SIGNED 9/3/63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 9/5/1963 | |
| 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St Louis Mo | |
| 24. FUNERAL DIRECTOR Ortmann F Home 9222 Lackland Overland Mo | | 25. DATE RECD. BY LOCAL REG. SEP 3 1963 | |
| 26. REGISTRAR'S SIGNATURE Loan Smith M.D. | | | |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Al C. Ortman

Licensed Embalmer No. 3478

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.